The Health of New Hampshire's Community Hospital System

A Financial Analysis

Concord Hospital




Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

February 2001

Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire*.

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

Acknowledgements

The Department wishes to thank the following individuals and organizations for making this financial analysis possible. First, this project was made possible through a grant from The Robert Wood Johnson Foundation's *Access Project*, directed by Catherine Dunham, Ed.D. Second, Dr. Nancy Kane and her graduate students at the Harvard School of Public Health prepared the financial analysis and narratives. Finally, the Department extends its appreciation to the Chief Financial Officers and Presidents of each New Hampshire hospital for reviewing the standardized financial spreadsheets and financial analysis to ensure their accuracy.

For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

CONCORD HOSPITAL, CONCORD, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Concord Hospital is a 161-bed, acute-care facility in Merrimack County[3]. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (51 and 36%, respectively)[4].

Capital Region Healthcare Corporation is the nonprofit parent company of the hospital. As a member of this System, Concord Hospital is affiliated with New London Hospital Association, Monadnock Community Hospital and several other nonprofit and for-profit organizations, including provider and home health services organizations. The hospital acquired a sports medicine clinic in 1998 from one of its affiliates.

Summary of Financial Analysis 1993-98
Concord Hospital's financial performance over the period was good, though profitability became more dependent on nonoperating activities in recent years and cash transfers and loans to affiliates absorbed significant resources.

Cash Flow Analysis 1993-98
The hospital generated 80% of its cash from internal sources: net income was the largest cash source (41%), due more to nonoperating revenues (26% of total cash sources) than operating income (15%), and depreciation generated an additional 39% of the hospital's total cash sources. Long-term borrowing was used to refinance and augment existing debt. Long-term debt provided the hospital with an additional 13% of its total cash over the period.

The greatest use of cash was investment in property, plant and equipment (PP&E), which represented 43% of the total cash uses. This level of investment ($38M) exceeded depreciation expense over the period ($34M), although averaged age of plant increased by 2 ½ years over the period. The average age of plant is still slightly younger than the state median as of 1997.

Affiliates absorbed an additional 28% of the hospital's total cash over the period. Transfers between the hospital and members of the System, specifically the parent, the property management company and a physician provider group, represented a net outflow from the hospital of $11M. The hospital distributed an additional $14M in loans to members of the System.

Almost one-quarter of the hospital's cash was used to increase marketable securities. This enabled the hospital to build liquidity, though it did not build cash balances as large as some other New Hampshire hospitals during this period.

Ratio Analysis 1993-98[5]
Profitability
Total profitability was strong and grew steadily from 2 to 11% until 1998, when it fell to 8% following a drop in the operating margin. As of 1997, this level of profitability placed Concord in the highest 10th

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.
[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

percentile in the state. These high total margins were driven by nonoperating revenues, which generally contributed more than 50% of the bottom line in recent years.

Operating income was erratic over the period. Growth in the markup was slow relative to the growth in revenue deductions due to payer discounts and contractuals (deductible) until 1997, when the markup grew twice as fast as the deductible, producing an operating margin of 5%. This level of growth was not maintained the following year, possibly due to a change in payer mix or pressure, and the operating margin dropped to 3% in 1998.

The hospital relied on the performance of the stock market in recent years to boost its bottom line. Realized gains on the sale of investments generated as much as three-quarters of the nonoperating revenues and more than a third of the bottom line by 1998.

Liquidity

Liquidity overall is good. The current ratio illustrates that the hospital has sufficient resources to cover short-term obligations, though the acid test ratio, a more stringent measure of liquidity, shows that the hospital's short-term assets are mainly comprised of less liquid resources, namely patient and affiliate receivables. By 1998, this measure dropped sharply as the hospital nearly depleted its current cash account. Despite the drop in current liquid assets, the hospital has more than enough resources to cover its short-term obligations when unrestricted marketable securities are considered.

Though the number of days cash on hand is low relative to the state median and drops to only 2 days cash by 1998, this reflects the hospital's priority on investing in noncurrent marketable securities rather than building the cash account. However, with the inclusion of unrestricted marketable securities, the hospital has 155 days of unrestricted cash on hand by 1998.

Although days in accounts receivable showed some improvement prior to 1997, this measure is above the state median as of 1997, indicating slower collections than other hospitals. The sharp increase in this measure to over 70 days in 1998 is of concern, although vendor payment remains fairly fast at 46 days.

Capital Structure

Concord Hospital has assumed more financial risk than most New Hampshire hospitals, though well within national norms. The equity financing ratio shows that the hospital has financed 50% of its assets with debt sources of capital (both short- and long-term). While most hospitals in the state reduced long-term debt over the period, Concord Hospital's level of financial risk remained roughly the same over the period.

Coverage ratios show that the hospital produced enough cash flow from yearly income to cover its debt principal and interest payments easily, even when only cash from operating income was considered. Cash flow to total debt was fairly stable with the exception of the years in which debt was issued.

Charity Care and Community Benefits

Charity care reported as charges forgone represented less than 1-2% of gross patient service revenues from 1993 to 1998 and declined in recent years. This amount of charity care met the estimated value of the hospital's tax exemption in 1993. With the inclusion of 50% bad debt, the hospital met its estimated tax value from 1994 to 1996. After 1996, in the hospital's most profitable years, charity care plus100% bad debt did not meet this benchmark.

The hospital did not report additional quantifiable charity care in the footnotes to its financial statements.

Concord Hospital's role as a teaching hospital, its operation of a trauma center and its HIV/AIDS services[1] may be considered additional charitable benefits to the community.

Cash Flow Analysis 1993 – 1999

Between 1993 and 1999, Concord Hospital received most of its sources of cash from internal sources, approximately 86%. Depreciation made up 39%. Non-operating revenues were at 26%, while operating income was 17%.

During this time period, property, plant, and equipment (PP&E) represented the largest use of cash. The level of investment - $44 million - was larger than depreciation expense of $42 million. The average life of the plant was 8.62 years. Affiliates' transactions represented the next largest use of cash at 26% of the hospital's total cash. Transfers between the hospital and members of the system, specifically the parent, the property management company, and a physician provider group represented a net out-flow of $12.6 million from the hospital. The hospital distributed an additional $15.7 million in loans to members of the system. Marketable securities were 18% of the hospital's total cash use during this period.

Ratio Analysis 1999

Profitability

In 1999, the total margin for Concord Hospital, Inc. was 8 percent (unchanged from 1998). The operating margin increased slightly from 3% in 1998 to 4% in 1999. Mark-up increased from 1.57 to 1.69. Deductions increased slightly from 30% to 33% of gross patient revenue.

Total operating revenue increased 18% from 1998 to 1999, while operating expenses increased 16%.

Liquidity

The hospital's overall liquidity is good. The current ratio increased from 3.37 in 1998 to 4.28 in 1999. The current ratio without board-designated marketable securities is up from 1.26 to 1.94. The ratios revealed that the hospital had sufficient resources to cover its current obligations. Its acid ratio increased significantly from 3% to 42%, and showed that its current assets are increasingly comprised of liquid resources.

Days in accounts receivable decreased slightly from 72.57 days in 1998 to 71.30 days in 1999. The hospital's collection rate was between the 50th percentile and the 75th percentile of New Hampshire's 1999 hospital industry. Concord Hospital collection rate was above the 1997 regional and national medians of 60.5 days and 62.8 days respectively. The average pay period decreased from 45.96 days in 1998 to 40.18 days in 1999, revealing that the hospital was paying its vendors approximately four days faster. Days cash on hand increased significantly from 2 days to 24 days, and days cash on hand including board-designated marketable securities increased from 155 days to 162 days. It significantly increased its cash and investment balances from $0.5 million to $6.9 million due to the increase in profitability, as well as lower levels of affiliate transfers and property, plant and equipment (PP&E) investments.

Capital Structure

The hospital's equity financing ratio was up slightly from 50% to 53%, indicating that it financed 53% of its assets with equity. Concord Hospital assumed more financial risk than most New Hampshire hospitals. However, it was still at or below 1997 national and regional medial levels of 0.53 and 0.60 respectively. Cash flow to total debt was up slightly from 24% to 27%. This ratio was above the 1999 New Hampshire industry median of 0.21 and also above 1997 regional and national medians of 0.21 and 0.26. The debt service coverage ratio was up from 3.85 to 4.76. Debt service coverage ratio with operating income increased from 2.79 to 3.63. The hospital was in a good position to service its long-term debt.

Charity Care and Community Benefits
Charitable care in the form of forgone charges as a percentage of gross patient service revenue increased slightly from 1.48% to 1.69%. Bad debt charges to gross patient service revenue increased slightly as well, from 4.16% to 4.32. The hospital did not report additional quantifiable charity care in footnotes to its financial statements.

Summary
Effective October 1, 1998, Capital Region Health Care Development Corporation (CRHCDC), Capital Region Health Care Venture Corporation (CRHVE), and Capital Region Physician Group Corporation (CRPCC) became affiliates of the hospital. (The transaction was accounted for similar to a pooling of interests under Accounting Principle Board Opinion No. 16). Accordingly, the consolidated financial statements for the period presented were restated to include the combined results of the financial position, operation, charges in net assets, and cash flows of the hospital and affiliates.

Concord Hospital's financial performance over the period was good, though profitability became more dependent on non-operating activities in recent years. In addition, cash transfers and loans to affiliates absorbed significant resources.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health